## ! IMPORTANT

Don't include this instruction page with your faxed or mailed claim form.

## FILLING OUT YOUR CLAIM FORM

### 1. Account Holder Information

Please print or write legibly when completing the account holder first and last name. Complete a separate form for your spouse and/or covered dependents.

### 2. Claims for Out-of-Pocket Expenses

This section should be filled out according to how your Medicare Part B premiums are paid.

**Check the first box** if your Medicare Part B premium is deducted from your Social Security or Annuity check.

**Check the second box** if your Medicare Part B premium is not deducted from your Social Security or Annuity check and is paid by you on an after-tax basis.

Your service start date is either January 1 of the year for which you are requesting reimbursement, your effective date if after the first of the year, or the first of the month(s) if you pay out-of-pocket on a monthly/quarterly basis.

Your service end date is either December 31 of the year for which you are requesting reimbursement or the last day of the month(s) if you pay out-of-pocket on a monthly/quarterly basis.

Fill in the total annual or monthly/quarterly amount of your Medicare Part B payment.

### 3. Proof of Payment

Attach proof of Medicare Part B premium payment.

### SELECTING YOUR PROOF OF PAYMENT DOCUMENTS

The Internal Revenue Service (IRS) requires you to provide documents to verify that you paid for a Medicare Part B premium. At a minimum, the document(s) must show:

- ✓ **The date you paid your Medicare premium**

- ✓ **The Medicare Part B account holder's name**

- ✓ **The name of your insurance carrier (Blue Cross and Blue Shield Service Benefit Plan)**

- ✓ **The type of expense (Medicare Part B premium)**

- ✓ **Proof of premium payment (such as a cleared check, bank statement, or credit card statement that shows the amount you paid for the Medicare Part B premium)**

**BlueCross BlueShield** Federal Employee Program®

**HealthEquity**®

# MEDICARE REIMBURSEMENT ACCOUNT (MRA)
PAY ME BACK CLAIM FORM

- Print or write legibly.
- Do not use a fax cover sheet.

**Submit your completed claim via toll-free fax:** (877) 353-9236
**OR mail:** Claims Administrator, PO Box 14053 Lexington, KY 40512

## 1 MEMBER INFORMATION

Last Name

First Name

| B | C | B | S | | S | E | R | V | I | C | E | | B | E | N | E | F | I | T | | P | L | A | N | | | |

Employer Name

ID Code*

Your ID code is a 4-digit combination of your day of birth and the last 2 digits of your SSN. For example, if you were born on the 8th day of the month and the last 2 digits of your SSN are 12, your ID Code would be 0812.

Date of Birth (MM/DD)

Zip Code

## 2 CLAIMS FOR OUT-OF-POCKET EXPENSES

**Check one:**

☐ My Medicare premiums are automatically deducted from my Social Security or Annuity check. (Enter annual amount)

☐ I pay my Medicare premiums after-tax. They are not automatically deducted from my Social Security or Annuity check. (Enter monthly/quarterly amount)

Service Start Date
(MM/DD/YY)

Service End Date
(MM/DD/YY)

$ Out-of-Pocket Cost

## 3 SUBMIT YOUR PROOF OF PAYMENT

Include proof of payment as an attachment to this form that shows you pay Medicare Part B premiums. Remember to keep the originals of the documents you submit.

If you checked the first box in step 2 above, please submit a copy of your Cost of Living Adjustment (COLA) statement or Annuity Statement.

If you checked the second box in step 2 above, please submit a copy of your Medicare Bill along with your proof of payment (such as a cleared check or bank or credit card statement).

Date _____

I certify that the information on this form is accurate and complete. I am requesting reimbursement for Medicare Part B premium expenses I incurred while a member of the Blue Cross and Blue Shield Service Benefit Plan. I have not/will not seek reimbursement of this expense from any other plan or party because I:
1) pay for the premiums through withholding, 2) have paid for the premiums out-of-pocket.

Use of this service indicates my acceptance of the User Agreement at fepblue.org/mra (available upon registration; enter username and password or click on First Time User).

4416-BCBS-MRA-PMB-FRM (202007)